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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

MICHAEL FRANKS, an individual,

Plaintiff,

vs.

AETNA LIFE INSURANCE COMPANY; THE SPRINT/UNITED MANAGEMENT COMPANY LONG TERM DISABILITY PLAN; SPRINT/UNITED MANAGEMENT COMPANY, in its capacity as Plan Administrator,

Defendants.

CASE NO. CV 10-3880 CW

DEFENDANTS' NOTICE OF MOTION AND MOTION FOR SUMMARY JUDGMENT, AND MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT

[ERISA, 29 U.S.C. Sections 1001 *et seq.*]

Date: December 8, 2011
Time: 2:00 p.m.
Courtroom: 2
Judge: Hon. Claudia Wilken

Accompanying Papers:
1) Declaration of Tad Devlin;
2) Declaration of Sabrina Misiaszek
3) [Proposed] Order.

Complaint Filed: August 30, 2010

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NOTICE OF MOTION AND MOTION

TO PLAINTIFF AND HIS ATTORNEY OF RECORD:

PLEASE TAKE NOTICE that on December 8, 2011 at 2:00 p.m., or as soon thereafter as counsel may be heard in Courtroom 2 of the above-entitled Court located at 1301 Clay Street, Oakland, California 94612, Defendants Aetna Life Insurance Company ("Aetna"), The Sprint/United Management Company Long Term Disability Plan, and Sprint/United Management Company (together "Sprint Defendants," together with Aetna "Defendants") move the Court to grant summary judgment because Aetna already awarded plaintiff Michael Franks long-term disability benefits, and is current on all benefits payments. The lawsuit is moot now and was premature when it was filed.

As Franks and his counsel are aware, Aetna's final claim decision on appeal was pending (and timely) when Franks filed suit. Counsel for Aetna met and conferred with Franks' counsel about dismissing the suit, but Franks refuses to do so, presumably in an effort to try to recover fees and costs from Aetna, when none are due. Instead, Aetna has been forced to bring this motion, and reserves rights to seek reasonable fees and costs from Franks and his counsel related to this motion. Franks, having been put back on benefits, has no legitimate remaining claims and did not by this lawsuit achieve success on the merits entitling consideration of a fee award under *Hardt v. Reliance Std. Life Ins. Co.*, 130 S. Ct. 2149 (2010).

Since the time Aetna advised Franks, through his counsel, of its claim decision, the handling (that Franks' counsel will likely reference in opposition to this motion) has been purely administrative, and attorney involvement has only slowed the process and *payment* of Franks' benefits. Further claim administration (e.g., document exchanges between the parties and payment of benefits) does not, and should not, involve judicial supervision and certainly does not require adjudication. Franks has no valid claims and can always reinitiate litigation, if necessary.

As a matter of law, Franks' lawsuit and prayer for relief should be dismissed, based on the following grounds:

1. Franks failed to exhaust his administrative remedies prior to filing suit against Defendants;

2. Franks has been and is receiving benefits, so his first cause of action is moot;

3. Franks' second cause of action for breach of fiduciary duty is duplicative of his first cause of action and seeks the same relief; as such, it is moot;

4. Franks' second cause of action is also nonjusticiable, because the declaratory relief he seeks is moot as to past benefits and unripe as to future benefits; and,

5. Franks is not entitled to any additional relief - attorneys' fees and prejudgment interest – and he has no claim on which relief can be granted.

This motion is based on this Notice of Motion and Motion, the accompanying Memorandum of Points and Authorities, the declarations of Tad Devlin, and Sabrina Misiaszek in support of this motion, the records and pleadings on file in this action, and upon such further evidence, either oral or documentary, as this Court may consider at the hearing on this Motion.

Defendants reserve the right for oral argument on this motion.

MEMORANDUM OF POINTS AND AUTHORITIES

Pursuant to Federal Rule of Civil Procedure 56 and Local Rules 3-4, 7-2, 7-4, and 56, Defendants bring this motion for summary judgment.

INTRODUCTION

Franks is and has been receiving LTD benefits from Aetna and will continue to do so through the "any occupation" period until retirement, contingent on his continued qualification for benefits under the Plan. In other words, barring a cure or treatment for the condition that precludes him from working, Franks will receive LTD benefits from Aetna until 2013. His lawsuit was premature when filed and is now moot.

Franks failed to exhaust his administrative remedies before bringing this suit. When Aetna told Franks it was about to render its appeal decision, Franks preemptively sued Aetna before it could issue its appeal decision *awarding* benefits to Franks. This alone is a complete defense to this action.

Each and every cause of action Franks asserts is nonjusticiable at this point. Aetna's ongoing payment of his benefits renders his demand for benefits under his first cause of action moot. His claims for declaratory and other equitable relief under his second cause of action are

either moot or unripe. Franks' failure to achieve any success on the merits means he should not obtain any further relief from this Court in terms of prejudgment interest or attorney's fees, which are driving the continued litigation by Franks and his counsel.

Following Aetna's initial denial of benefits, Franks' counsel held up Aetna's appeal process for more than nine months by his dilatory practices, to wit: delays in providing the information Aetna needed; delays in evaluating the information he was given; delays in even ministerial tasks. On the eve of Aetna's appeal determination (and after having been advised by Aetna it was about to render a decision), Franks filed this lawsuit. By the ERISA-mandated deadline, *see generally* 29 C.F.R. § 2560.503-1(h) and (i), Aetna had made its decision to award Franks disability benefits.

Although Aetna has been paying benefits to Franks since October 2010, Franks still refuses to dismiss this case, essentially holding Aetna hostage under the threat of the second claim for relief, which seeks the exact same relief already being provided to Franks: his LTD benefits. He uses this improper claim to argue the continuing viability of his demands for pre-judgment interest (even though no judgment was issued) and attorney's fees (even though none are proper under clear and controlling authority). His counsel continues to demand that all routine claim communications by Aetna run through counsel, for no apparent reason other than to allow counsel to increase his billable hours, thereby to justify his demand for considerable fees on a case that was, in effect, decided in Franks' favor before it was filed.

In short, Franks can achieve nothing with this lawsuit except to burden this Court and Defendants with unnecessary and continued litigation. For these reasons, Defendants respectfully request the Court grant summary judgment. Defendants are also considering a separate motion for attorneys' fees and costs incurred in having to bring this motion.

RELEVANT FACTS

A. The Sprint Long Term Disability Plan

Plaintiff Michael Franks is a covered employee under the Sprint/United Management Long Term Disability Plan (the "Plan"). (Declaration of Sabrina Misiaszek ("Misiaszek Decl." at ¶ 2.) The Plan pays a monthly benefit for a period of disability caused by a disease or injury.

(*See id*. at Exh. 31 [SPD at pg. 2].) For the first twenty-four months after a participant's date of disability, a participant is considered disabled if he is not able to perform the material duties of his own occupation solely because of disease or injury. (*Id*.) After this initial "own occupation" period, a participant is considered disabled if his disease or injury renders him unable to work at any reasonable occupation, referred to as the "any occupation" period. (*Id*.)

The Plan has an elimination period of 180 days. (*See id*. at Exh. 30 [Summary of Coverage at pg. 3.].) Under the Plan, Aetna has 45 days to review an appeal, and can get an extension of up to 45 days on written notice. (*See id*. at Exh. 31 [SPD at pg. 18]); and *see also* 29 C.F.R. § 2560.503-1(h) and (i).

Franks last worked on August 30, 2008, so after the 180-day elimination period, his date of disability was calculated as February 26, 2009. (*See id*. at Exh. 1.) Thus, Franks' "own occupation" period ran through February 25, 2011, and the "any reasonable occupation" period began on February 26, 2011. (*See id*. at Exh. 27.)

B. Initial claim review

On or about March 9, 2009, Franks submitted documentation related to his claim for long-term disability benefits. (*Id*. at ¶ 4.)

On June 19, 2009, Aetna denied the claim based on a lack of sufficient medical evidence supporting a finding he was disabled. (*Id*. at ¶ 6, Exh. 3.) Aetna notified Franks that it would consider additional information and specifically identified the information that would assist in its further claim evaluation. (*Id*.)

C. Franks' appeal of the claim decision

The appeal process lasted from July 7, 2009, when Franks' attorney, Julian Baum, submitted a notice of intent to appeal, until October 1, 2010, when Aetna notified Franks' counsel of its decision to award benefits. (*Id*. at ¶ ¶ 4, 33, Exh. 4; and Declaration of Tad Devlin ("Devlin Decl.") at ¶ 5.) During those fifteen months, Aetna met the ERISA-mandated 45-day review period, plus one 45-day extension. (Misiaszek Decl. at ¶ 25; Exh. 21.) The remaining twelve months consisted of exchanges of information and delay caused by Franks' counsel.

Here are some examples:

- On July 7, 2009, Mr. Baum wrote Aetna notifying it of Franks' intent to appeal. He requested Aetna and/or the Plan administrator provide the claim file, all other information related to Franks not contained in the claim file, and documents to which Franks was entitled under ERISA. Although no litigation was pending, Baum also requested a log of all documents Aetna withheld and the basis on which they were not provided. (*Id*. at ¶ 7, Exh. 4.)
- Three weeks later, on July 28, 2009, Baum provided Franks' signed authorization to allow Aetna to provide Baum with documents, records or information Aetna requested, but modified the form to limit the authorization to August 1, 2010, restricting Aetna's ability to obtain information. Baum also reiterated his document requests. (*Id*. at ¶ 8, Exh. 5.)
- On September 2, 2009, Sprint sent Baum the Plan-related documents he requested. (Devlin Decl. at ¶ 2, Exh. 1.)
- On September 15, 2009, Aetna mailed Baum a "summary of all claims submitted to Aetna on behalf of" Franks in response to his document requests. (Misiaszek Decl. at ¶ 9, Exh. 6.)
- On November 6, 2009, Baum sent Aetna Franks' appeal letter, which consisted entirely of demands for additional information, but provided no new medical records or information. Baum indicated he could not complete Franks' appeal without Aetna's internal claims assessment guidelines and the group policy.[1] Franks provided no new information to Aetna. Thus, the administrative correspondence between Aetna and Baum in reality was about Baum's repeated requests for information from Aetna.

Although Baum also demanded Aetna inform him "what you consider necessary to perfect Mr. Franks' claim for benefits," Aetna had already provided the information requested by Baum in its June 19, 2009, denial letter. Franks' entire appeal consisted of

[1] Ultimately, Baum does not reference or cite any of these internal documents in Franks' final appeal letter. His silence suggests that his review of Aetna's claims practices did not yield a finding that Aetna had handled Franks' claim wrongfully. At all times, Aetna acted properly, reasonably, timely (under the Plan and the ERISA rules and regulations), and in fact came to the final decision to award benefits. This lawsuit had no impact on the claim decision.

demands (some duplicative) for more information from Aetna and Sprint. (*Id*. at ¶ 10, Exh. 7.)

- On December 2, 2009, Aetna informed Baum it began its appeal review as of November 9, 2009, the day Aetna received the appeal request; and that Aetna would render its appeal decision within 45 days. (*Id*. at ¶¶ 11, 12, Exh. 8.)
- On December 4, 2009, Aetna wrote Baum to confirm an earlier conversation in which Baum requested "additional time to submit medical documentation" for the appeal review. Baum represented that additional information existed to support Franks' claim, so Aetna agreed to place its review on hold until January 17, 2010, by which time Baum needed to provide that information. (*Id*. at ¶ 13, Exh. 9.)
- On January 6, 2010, Aetna sent Franks an additional 600 pages of documents. (*Id*. at Exh. 10.) As a result, Baum requested Aetna further postpone its appeal review to allow him time to review the additional information. Aetna granted this request. (*Id*.)
- On January 27, 2010, Aetna granted another request by Baum to postpone the appeal review, this time until April 14, 2010. (*Id*. at ¶ 15, Exh. 11.)
- On April 14, 2010, Baum sent Aetna additional medical records from Franks' treating doctors. He also provided his completed appeal letter which consisted of his one-page account of Franks' condition. Baum made no reference to and did not cite any of Franks' medical records, nor any of the purportedly essential documents outside the administrative record he claimed to have needed. Almost two-thirds of Baum's letter is devoted to a reiteration of his demand for additional documents outside the claim record. (*Id*. at ¶ 16, Exh. 12.)
- On April 19, 2010, Aetna notified Baum his request for documents beyond the claim record had been forwarded to the appropriate group, and a separate response would be issued. Aetna further postponed the appeal review at Baum's request because he represented that additional information was available to support Franks' claim. (*Id*. at ¶ 17, Exh. 13.)
- On May 12, 2010, Lisa Lawrence, Esq., also Franks' counsel, notified Aetna she had not

obtained a report from Franks' cardiologist, but would forward it to Aetna. (*Id*. at ¶ 18, Exh. 14.)

- Because of the representation by Franks' counsel that potentially relevant information was outstanding, on May 17, 2010, Aetna again postponed the appeal review to allow Franks more time to provide the medical documentation Franks' counsel referenced. (*Id*. at ¶ 19, Exh. 15.)
- On June 9, 2010, Aetna responded to the ongoing demands of Franks' counsel for documents. Although most of the documents already had been produced, Aetna provided additional documents beyond the claim record. Aetna again reiterated to Baum the information needed to perfect Franks' claim. (*Id*. at ¶ 20, Exh. 16.)
- On June 22, 2010, and again on July 7, 2010, Baum requested additional time to obtain information, and Aetna postponed the appeal review accordingly. Aetna informed Baum that once it had the information he promised, a decision would be rendered within 20 days unless an extension was needed. (*Id*. at ¶¶ 21, 22, Exhs. 17, 18.)
- On July 13, 2010, Baum provided the cardiologist's report to Aetna with a letter stating that he "believe[d] that Aetna now has everything it needs." He asked Aetna to notify him of anything further necessary to perfect Franks' appeal. Twenty days from July 14, 2010 (when the report was received) was August 2, 2010. (*Id*. at ¶ 23, Exh. 19.)
- On July 30, 2010, before the expiration of 20 days on August 2, 2010, Aetna informed Baum it needed the additional 45-day extension, and thus the appeal review would be completed by September 17, 2010. (*Id*. at ¶ 25, Exh. 21.)
- On or around August 12, 2010, Lisa Lawrence, Esq., Franks' co-counsel suggested that there still was additional, potentially relevant information outstanding. Consequently, Aetna tolled its appeal further, until August 25, 2010, to allow Franks additional time. This pushed the appeal deadline back to October 2, 2010, and Baum was so informed. (*Id*. at ¶ 28, Exh. 24.) However, **Baum refused to provide the additional information Lawrence referenced,** and instructed Aetna to base its appeal on what it had. (*Id*. at ¶ 27, Exh. 23.) In this same timeframe, Aetna and Baum exchanged several letters about

the need for Franks to sign an updated authorization for release of medical records. (*Id*. at ¶¶ 26, 29, Exhs. 22, 25.)

In the parties' communications during these three-weeks, Baum never suggested Aetna's review was taking too long, or the appeal decision date was objectionable or in any way improper. Conversely, Aetna never deemed Franks' administrative remedies exhausted. (*Id*. at ¶¶ 26, 29, 30, Exhs. 22, 25.)

- On August 18, 2010, Baum's last letter to Aetna before commencing litigation, Baum reiterated his request that Aetna refrain from putting Franks' appeal "on hold" until August 25. (*Id*. at ¶ 29, Exh. 25.) While Baum stated his belief Aetna had enough information to approve the claim, he did not indicate Franks intended to file suit if Aetna retained its original timeframe, or that he thought Franks had exhausted his administrative remedies. (*Id*.)

Without any further communications from Baum or Franks, Franks filed his complaint on August 30, 2010 – less than two weeks later. (Devlin Decl. at ¶ 47, Exh. 42.)

To summarize, Baum took four months just to submit Franks' appeal letter, thus postponing the appeal review until November 9, 2009. Then, because of Baum's repeated requests for extra time, the appeal review ended up being tolled for 238 days total – almost 8 months. (Misiaszek Decl. at ¶ 34.) The administrative process was delayed by almost a full year because of Baum's dilatory handling of Franks' appeal. Despite this, in his last pre-lawsuit correspondence, Baum insisted Aetna provide an immediate appeal determination well before the ERISA-mandated deadline. (*Id*. at ¶ 29, Exh. 25.)

At the time of Baum's August 18 letter demanding immediate reinstatement, Franks' appeal still was squarely within the administrative review period. (*Id*. at ¶ 29, Exh. 25.) Aetna never agreed to complete its review earlier than August 25. (*Id*. at ¶ 30.) The ERISA-approved deadline by which to provide its response was October 2, 2010. (*Id*. at ¶ 28, Exh. 24.) Even if Baum disagreed with the decision to toll the review until August 25, the earlier appeal deadline without the tolling would have been September 17, 2010. In either case, Franks' complaint was filed before the appeal decision, which *awarded* benefits, timely on October 1, 2010. (*Id*. at ¶

33.)

D. The pleadings

Franks initially alleged three causes of action in his complaint: a claim for benefits due under an ERISA plan; breach of fiduciary duty; and failure to provide ERISA documents. Upon his counsel being reminded that plan documents had been timely provided to him nearly a year earlier, Franks dismissed the third cause of action for failure to provide ERISA documents. (*See* Devlin Decl. at ¶ 47, Exh. 42 ("Complaint").)

For his first claim, although Aetna had not issued its appeal decision, Franks contends that "Defendants have failed and refused to pay Franks disability benefits to which Franks is entitled under the terms of the Plan." (Complaint at ¶ 7.) Baum delayed providing necessary documents to Aetna for nine months, yet Franks alleges in the complaint that "Defendants unreasonably and wrongfully fail[ed] to conduct and complete timely a proper investigation and review of plaintiff's claim." (*Id*. at ¶ 9.) Franks contends he suffered damages of "loss of disability benefits, interest on those benefits, and attorneys' fees and expenses." (*Id*. at ¶ 10.)

For his breach of fiduciary duty claim, Franks re-alleges that Aetna failed to investigate completely and timely, failed to provide a full and fair review, and failed to administer Franks' claim in accordance with the Plan. (*Id*. at ¶ 12) Other than these allegations, Franks does not specify what exactly Aetna did or did not do, or what Plan requirements were not met. For this cause of action, just like his first cause of action for benefits, Franks seeks an award of benefits, and also declaratory relief "clarifying his rights under the Plan." (*Id*. at ¶ 13.)

On November 24, 2010, Aetna and Sprint answered the complaint.[2] (Devlin Decl. at ¶¶ 48, 49, Exhs. 43, 44.) The answers generally deny the allegations and assert affirmative defenses, including failure to state a claim on which relief may be granted; and failure to exhaust administrative remedies.[3] (*Id*. at Exh. 43 (pgs. 3, 4), and Exh. 44 (pg. 3).)

E. Post-lawsuit claim administration

On September 9, 2010, less than a month before Aetna's anticipated appeal decision,

[2] At that time, the Defendants were represented separately.

[3] Because Franks' allegations about entitlement to benefits are moot at this point, and the breach of fiduciary duty claims are both moot and unripe, Defendants do not recite all of their applicable affirmative defenses here.

Baum provided Aetna's counsel with 448 pages of additional documents he had obtained from Franks' medical providers. (*Id*. at ¶ 3, Exh. 2.) Apparently, these were the documents Baum had told Aetna were outstanding. (*Id*.) He did not provide these documents before filing Franks' complaint.

On October 1, 2010, Aetna determined Franks was entitled to disability benefits from his date of disability to the then-present. (Misiaszek Decl. at ¶ 33.) Because of the pending litigation, Aetna communicated its determination to award Franks benefits orally through its counsel on October 1, 2010. (*Id*.; *see also* Devlin Decl. at ¶ 5.) The written confirmation of this decision was sent to Baum by facsimile on October 14, 2010. (Misiaszek Decl. at ¶ 36, Exh. 27.)

The award letter specified that Franks

> does currently meet the Plan's 'own occupation' definition of disability effective February 26, 2009. Therefore, the original decision to deny LTD benefits has been overturned and [plaintiff's] claim has been re-opened. He will receive LTD benefits for the period February 26, 2009, through September 30, 2010.

(*Id*.)

Aetna also specified that Aetna "will contact you regarding [plaintiff's] eligibility for ongoing benefits." (*Id*.)

Ultimately, Aetna awarded Franks benefits for the entire own occupation period: February 26, 2009, through February 25, 2011. (*Id*. at ¶¶ 36-39, Exhs. 27-29.) Aetna also determined Franks was entitled to benefits under the "any occupation" standard beginning February 26, 2011. (*Id*.) Franks has and will continue to receive his benefits from Aetna, subject to the Plan terms. Franks has been awarded, and has been paid up to the present, benefits for the entire period for which he could be eligible for benefits. (*Id*.)

F. Franks' counsel has unnecessarily hindered the claim administration process, disguised as litigation efforts

Baum's continued involvement in the now-moot lawsuit has resulted in unnecessary delays in the claim administration (e.g., payment, calculation of any applicable offsets and further claim qualification).

On November 29, 2010, Aetna had informed Baum it needed Franks to complete certain forms and provide additional medical information for benefits beyond September 30, 2010. (Misiaszek Decl. at ¶ 37, Exh. 28.) Baum failed to provide the requested information until February 8, 2011 (*Id*. at ¶ 38, Exh. 29), which resulted in a delay of benefit payments for four months.

Under the Plan, Aetna is entitled to an offset for, among other things, an award of Social Security benefits. (*Id*. at ¶ 40.) Baum failed to provide outstanding information about Franks' Social Security benefits award for almost four months. (Devlin Decl. at ¶ 38, Exh. 33.) Finally, Baum informed Aetna that Franks did not have the additional information, and Aetna should get it directly from the Social Security Administration. (*Id*. at ¶ 39, Exh. 34.)

When Aetna calculates offsets under the Plan, it could impact Franks' monthly benefit payments. (Misiaszek Decl. at ¶ 40.) If there was an overpayment by Aetna, then it is entitled to repayment from Franks. If Baum had provided the SSA information earlier (which certainly Franks himself, without need of counsel, could have readily provided), or had Franks obtained the information from the SSA, the offset would have been calculated and there would have been less delay in Franks' receiving his benefit payment and less impact on the benefit payment amount and checks being passed between Franks and Aetna. In other words, what should have been simple requests for information and response turned into a tussle back and forth based on the attorney involvement, which was completely unnecessary. (*Id*.)

All of the pre- and post-lawsuit communication has been purely administrative, and seemingly used by Baum as justification for his continued involvement in Aetna's administration of Franks' claim. Every time Aetna has requested dismissal of this lawsuit, Baum has refused until certain new conditions were met. However, even after the conditions were met, the information was provided, and the questions were answered – whatever he has asked for – Baum (on behalf of Franks) refused and still refuses to dismiss the lawsuit. Instead, Baum has simply made requests for information that are irrelevant to the claim, duplicative of prior requests and certainly have no relationship to the litigation, which is moot. (*See* Devlin Decl. at ¶¶ 6, 8, 9, 16, 17, 24, 26-41, 43, 45; Exh. 4, 5, 6, 13, 20, 22-36, 38, 40.) Baum has argued his continued

involvement in the claim process somehow legitimizes his fee demand. (*Id*. at ¶ 23, Exh. 19.) Not so. He has done nothing but slow down the administrative process between Aetna and Franks, just as he did nothing to achieve success on the merits of this lawsuit (which was already decided by the reinstatement for benefits that Aetna did independent of the lawsuit).

LEGAL ARGUMENT

Defendants are entitled to summary judgment because the undisputed material facts show that Franks cannot succeed on the merits on either of his two causes of action. Summary judgment is appropriate when the record shows "there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(a); *see also Celotex Corp. v. Catrett*, 477 U.S. 317, 322-23 (1986); *Microtec Research v. Nationwide Mut. Ins. Co*., 40 F.3d 968, 970 (9th Cir. 1994).

Here, it is undisputed that Franks is receiving the relief (LTD benefits) he seeks. If Aetna denies benefits during the any occupation period, Franks can seek redress at that time, but not now.

A. Defendants are entitled to judgment as a matter of law because franks failed to exhaust his administrative remedies before filing suit

If Franks simply had waited until Aetna issued the appeal determination, then the lawsuit would have been unnecessary. The exhaustion of administrative remedies doctrine exists to avoid needless litigation. *See Amato v. Bernard*, 618 F.2d 559, 567 (9th Cir. 1980). Aetna and Sprint included this affirmative defense in their respective answers. (Devlin Decl. at Exh. 43 (pgs. 4), and Exh. 44 (pg. 3).)

ERISA requires a plan participant exhaust administrative remedies before instituting litigation. *See Amato, supra*, 618 F.2d at 566. Franks' failure to do so is grounds for summary judgment. *See id*. at 561. Here, Franks, through his counsel, was well aware that Aetna was evaluating his appeal when he filed his complaint, as evidenced by the numerous letters sent back and forth between Aetna and Franks' counsel. Aetna notified Franks he should not expect an appeal decision until October 2, 2010. Yet, Franks filed his complaint on August 30, 2010.

To the extent Franks argues delays in the administrative review process supported a

preemptive lawsuit, this argument is without merit.

Aetna was timely in its decision making under the Plan and ERISA rules and regulations. Any delays in the appeal review process were brought about by Franks and his counsel. Baum did not provide Aetna with any additional information or substantive argument as to why he believed Franks was entitled to benefits until April 14, 2010 - 281 days (more than 9 months) after Franks' notice of intent to appeal. It took counsel a month to provide Franks' authorization to allow Aetna to obtain his medical records. After Franks' April 14, 2010 appeal letter, Franks' counsel's requests to allow him more time to produce additional information resulted in a delay of an additional three months before Aetna could begin its appeal review. Aetna requested one 45-day extension during the claim administration, and Aetna timely communicated its claim decision to Franks. Franks' lawsuit was simply premature. *See Vaught v. Scottsdale Healthcare Corp. Health Plan*, 546 F.3d 620, 626 (9th Cir. 2008).

Although Baum contended in his correspondence with Aetna that he needed additional documents outside the administrative record to prepare Franks' appeal, when he got them he apparently did nothing with them. Franks' April 2010 appeal letter did not reference, rely on, or otherwise appear to make use of any information outside the administrative record. Baum did not reference any doctor notes, medical evaluations, or other health-related documents, and instead argued about Franks' poor health. Rather than cite to any of the medical records he was provided, Baum instead instructed Aetna to "confirm this information directly with [Franks' treating physician]." Of the four-page appeal letter, less than one page is dedicated to a discussion of why Franks was entitled to benefits.

In the parties' Joint Case Management Conference Statement [Dkt. 20], filed December 7, 2010, Aetna advised Franks, his counsel and the Court the claim was being decided by Aetna's appeals unit and the lawsuit was premature. Aetna further indicated there were no factual issues, because the benefits decision was pending and the lawsuit should be dismissed or stayed. As to the legal issues, in the joint statement, Aetna indicated the issue was whether the lawsuit was premature for failure to exhaust administrative remedies. (*See* Devlin Decl. at 18, Exh. 13A [12/07/10 Jt. Case Mgmnt. Stmnt.])

At the December 14, 2010 initial Case Management Conference, Aetna advised Franks' counsel and the Court of Aetna's claim decision instating Franks' LTD benefits. Aetna's counsel contended Franks' lawsuit was moot as to past benefits paid, and unripe as to future benefits. (*See* Devlin Decl. ¶ 18, Exh 13A) In response to the Court's inquiry about remaining issues, Baum pointed to the second cause action. However, Franks' second cause of action is duplicative of, and seeks the same relief as, the first cause of action for recovery of benefits.

B. Aetna is and has been paying LTD benefits to Franks and agreed to do so through the "any occupation" period subject to the Plan terms

Franks has been paid benefits for the entire period during which he claims disability. Franks is not owed any back benefits, and benefits have been awarded through the "any occupation" period, subject to the Plan terms. There is no unpaid benefit issue to litigate.

Federal courts only have the power to adjudicate "cases or controversies." *See* U.S. Const. Art. III, § 2. A case is nonjusticiable when it is moot – that is, "when the issues presented are no longer 'live' or the parties lack a legally cognizable interest in the outcome." *See City of Erie v. Pap's A.M.*, 529 U.S. 277, 287 (2000). A case may become moot at any point in the litigation, and the analysis does not end at the time of the complaint. *See Arizonans for Official English v. Arizona*, 520 U.S. 43, 67 (1997).

The test to determine whether a claim is moot is whether a court can afford "meaningful relief." *See West v. Sec. of Dept. of Transp.*, 206 F.3d 920, 925 (9th Cir. 2000).

Here, Aetna already determined Franks was entitled to benefits during the entirety of the own occupation period. (Devlin Decl. at ¶6.) Aetna has paid Franks all benefits due and owing during the own occupation period. (Misiaszek Decl. at ¶ 39.) Aetna determined Franks is entitled to benefits under the "any reasonable occupation" period, subject to the Plan terms. (*Id.* at ¶ 38, Exh. 29.) It also has paid those benefits. (*Id.* at ¶ 39.) Franks has been paid all benefits to which he is entitled. (*Id.*) There is no further remedy the Court can order on this claim for relief. As such, Defendants are entitled to judgment as a matter of law.

This Court reached the same conclusion in a recent case on similar facts. *See Minton v. Deloitte & Touche USA LLP Plan*, 2011 U.S. Dist. LEXIS 60398, *2, fn. 3 (N.D. Cal. June 3,

2011)(Wilken, J.). In *Minton*, the plaintiff sought long-term disability benefits the defendants ultimately awarded him. On plaintiff's subsequent summary judgment motion on his claim for the disability benefits, this Court ruled the plaintiff's "ERISA claim for an award of these benefits is moot." *See id*. at *2, fn. 1.

The situation here is the same. Franks' complaint seeks disability benefits, which Aetna has already awarded and paid, and continues to pay. Plaintiff's claim for benefits is moot, and there is nothing left for the Court to do.

C. Franks' claim for breach of fiduciary duty is the same as his claim for benefits and should be dismissed

Franks' second cause of action for breach of fiduciary duty is duplicative of his first cause of action. Thus, Franks' cause of action for breach of fiduciary duty is also moot and should be dismissed as a matter of law.

1. Franks' alternative demand for benefits is moot and legally improper

Defendants are entitled to judgment as a matter of law on any claim that Franks is entitled to an award of benefits. Franks' breach of fiduciary duty claim alleges that Defendants "fail[ed] properly and timely to investigate and administer Franks' claim for disability benefits, [failed] to provide a full and fair review of Franks' claim, and [failed] to administer the Plan in accordance with the purposes of the Plan and for the exclusive benefit of its beneficiaries." (Complaint ¶ 12.) As a result of these alleged failures, Franks seeks damages of "loss of disability benefits" and related compensatory damages. (*Id*. at ¶ 13.)

The only damages Franks claims to have suffered from the alleged breach of fiduciary duty is loss of benefits, which is the same relief sought in the first cause of action. For this claim to remain viable, this Court must be able to award Franks meaningful relief, yet none is available. *See West, supra*, 206 F.3d at 925. As discussed, Aetna already paid Franks the benefits he seeks. Nothing further being owed, Franks has no damages, and this Court cannot provide him with meaningful, or any additional relief.

Further, ERISA does not allow an individual plan participant (such as Franks) to seek compensatory damages for breach of fiduciary duty. *See Great-West Life & Annuity Ins. Co. v.*

Knudsen, 534 U.S. 204, 221 (2002). Here, Franks seeks compensatory damages: alleged lost benefits and related monetary damages. Even putting aside the mootness issue, Franks cannot obtain this relief.

2. Franks' breach of fiduciary duty claim is legally improper because he has another adequate remedy under ERISA

To the extent Franks seeks an equitable remedy, Defendants are entitled to summary judgment because plaintiff has another adequate remedy under ERISA. His first cause of action for benefits provides the same relief he seeks for his second cause of action for breach of fiduciary duty.

Although not specifically stated in the complaint, Franks' breach of fiduciary duty claim must be based on ERISA § 502(a)(3) because it is the only ERISA section authorizing such an action.[4] ERISA § 502(a)(3) authorizes a plan participant to sue to enjoin violations of ERISA or the terms of the plan or "for other appropriate equitable relief" to redress alleged ERISA violations. *See* 29 U.S.C. § 1132(a)(3); *see also Mathews v. Chevron Corp*., 362 F.3d 1172, 1183–1185 (9th Cir. 2004). Individual plan participants are only entitled to equitable relief. *See Great-West supra*, 534 U.S. 204. Thus, Franks' claim for breach of fiduciary duty only properly could seek equitable relief, not compensatory damages.

Franks could bring a breach of fiduciary duty claim to seek such equitable relief only if he had no other adequate remedy available to him under ERISA. That not being the case, Franks' breach of fiduciary duty claim fails as a matter of law.

Section 502(a)(3) is referred to as a "catchall" provision allowing relief for breach of fiduciary duty only when no other adequate relief is provided by ERISA. *See Varity Corp. v. Howe*, 516 U.S. 489, 508-516 (1996); *accord Great-West, supra*, 534 U.S. at 221 n. 5. Here, the damages Franks contends he suffered because of Defendants' alleged breach of fiduciary duty are "loss" of disability benefits. (Complaint at ¶ 13.) Because ERISA already provides an adequate remedy for this alleged loss under Section 502(a)(1)(B), a remedy Franks seeks in his

[4] While Section 502(a)(2) also authorizes an action for equitable relief, a plan participant can only bring this claim if seeking a benefit for the entire Plan.

first cause of action, Franks' breach of fiduciary duty claim is improper.

Franks cannot obtain equitable relief for the same loss as alleged in his claim for benefits. *See Ford v. MCI Communications Corp. Health & Welfare Plan,* 399 F.3d 1076, 1081, 1083 (9th Cir. 2005). A plaintiff whose injury consists of a denial of benefits "has adequate relief available for the alleged improper denial of benefits through his right to sue [the benefit plan] directly under section [502(a)(1)]," and thus "relief through the application of [Section 502(a)(3)] would be inappropriate." *Tolson v. Avondale Indus., Inc.*, 141 F.3d 604, 610-11 (5th Cir.1998); *see also Forsyth v. Humana, Inc.*, 114 F.3d 1467, 1474-75 (9th Cir.1997).

ERISA provides appropriate redress for an alleged failure to provide disability benefits under Section 502(a)(1)(B). Franks' attempt to re-label his demand for benefits as a claim for equitable relief for breach of fiduciary duty fails as a matter of law.

D. Franks' breach of fiduciary duty claim is nonjusticiable

The only remedies available for breach of fiduciary duty claim are equitable. However, any demand for equitable relief here is nonjusticiable. In his prayer for relief, Franks seeks "a declaration clarifying his rights under the Plan," and "such equitable relief as the Court deems just and proper." A claim for declaratory relief regarding past benefits is moot. A claim for declaratory relief regarding future benefits is speculative and unripe. Under the Plan, Aetna awarded Franks' benefits through the any occupation period, subject to the Plan terms and conditions. There is no need for judicial clarification of his rights under the Plan.

1. Equitable relief for past benefits is moot

Franks cannot be seeking relief concerning his past benefits, which have been paid. To the extent he is, the claim is moot. "[D]eclaratory relief is appropriate (1) when the judgment will serve a useful purpose in clarifying and settling the legal relations in issue, and (2) when it will terminate and afford relief from the uncertainty, insecurity, and controversy giving rise to the proceeding." *Eureka Fed. Say. & Loan Ass'n v. Am. Cas. Co.*, 873 F.2d 229, 231 (9th Cir. 1989)(holding declaratory relief proper because the basis for breach of fiduciary claim was on-going).

Here, Aetna has paid back benefits to Franks. Aetna does not owe him additional

benefits. There is nothing to clarify or settle with respect to Franks' back benefits. Further, there is no uncertainty or controversy and thus, no need for this Court's judgment concerning back benefits, which have been paid.

2. Equitable relief for future benefits is unripe and unnecessary

Aetna has determined that Franks is disabled under the any occupation standard, and has been paying him benefits accordingly. However, to obtain benefits for the remainder of the policy period, Franks must continue to satisfy the Plan's terms and conditions. Franks' future compliance with Plan requirements is unknown. Asking this Court to declare entitlement to future benefits would effectively substitute this Court as the Plan's claim administrator instead of Aetna. This would be an unworkable and an impracticable position for the Court and would ignore the provisions of the disability plan that obligate claimants to provide ongoing proof of their eligibility for continued benefits.

a. A declaration of Franks' future benefits inappropriately would make the court act as the claims administrator

Under ERISA, the Court's role is to *review* the propriety of a claim administrator's decision, not to *act as* the claim administrator by construing plan terms and making decisions that were never before a claim administrator in the first place. In *Vizcaino v. Microsoft Corp*., 120 F.3d 1006, 1013-1014 (9th Cir. 1997), the Ninth Circuit remanded an issue regarding benefits under an ERISA plan to the claim administrator when the particular question at issue had never been before the claim administrator to decide. *Id*. *Vizcaino* explained the determination of ERISA benefits involved an "issue of plan construction, one on which the administrator has not opined." *Id*. The court "should not allow ourselves to be seduced into making a decision which belongs to the plan administrator in the first instance. . .we cannot, and will not, predict how the plan administrator, who has the primary duty of construction, will construe the terms..." *Id*. The court stated:

> We would set a poor precedent were we to intrude upon that exercise of discretion before he [the claim/plan administrator] has even considered and ruled upon the issue. We would encourage the dumping of difficult and discretionary decisions into the laps of the courts, although one of the very purposes of ERISA is to avoid that kind of complication and delay. *Id*.

Here, if the Court decided Franks' entitlement to future benefits, it would adjudicate a question that Aetna has yet to decide. Franks has an on-going requirement to meet the definition of disability under the Plan, and to comply with the Plan's reporting requirements. The Court cannot now rule on Franks' entitlement to future benefits, which would essentially determine Franks' future functional incapacity, his qualification for disability benefits under the Plan and address questions never before the claim administrator. This would effectively void the Plan terms concerning the on-going qualification requirement.

b. Because Aetna has not denied franks future benefits, his claim is unripe

Franks cannot now seek adjudication regarding his entitlement to future benefits because they have not been denied. There is no issue for this Court to decide. *If* Aetna stops paying future benefits, *then* Franks can pursue his remedies available under ERISA. Until then, his claim is unripe.

Addressing declaratory relief, the U.S. Supreme Court held "the question in each case is whether the facts alleged, under all the circumstances, show that there is a substantial controversy, between parties having adverse legal interests, of sufficient immediacy and reality to warrant the issuance of a declaratory judgment." *Maryland Cas. Co. v. Pacific Coal & Oil Co.*, 312 U.S. 270, 273 (1941). A court cannot grant declaratory relief if the asserted controversy involves only future or speculative rights. *See City of Santa Barbara v. U.S.*, 269 F.Supp. 855, 862 (C.D. Cal. 1967); *see also Hunt v. State Farm Mut. Auto Ins. Co.*, 655 F.Supp. 284, 286 (D.Nv. 1987).

In a case where an ERISA plan participant sought a declaratory judgment that he was entitled to a specific benefits award for the rest of his life, the court granted summary judgment to the defendants. *See Stenson v. Jefferson Pilot Fin. Ins. Co.*, 2008 U.S. Dist. LEXIS 46298, *13, *18 (C.D. Cal. 2008). Because entitlement to future benefits depended on specific conditions precedent, the court could not order the declaratory relief plaintiff sought as it was too speculative. *See id.* at *15-*16. There was no ripe controversy between the parties because the plaintiff's benefits were being paid, and the defendants were not threatening to stop paying the

benefits. *See id*. at *16. Hence, any controversy was "purely hypothetical." *See id*.

The situation here is the same. Pursuant to the Plan terms, Aetna has determined Franks will continue to be entitled to benefits so long as he continues to meet the requirements for benefits. (*See* Misiaszek Decl. at Exh. 29.) These requirements include, for example, that Franks continue to meet the Plan's definition of disability under the "any reasonable occupation" standard, and remain under the regular care of a licensed physician appropriate for his condition. (*Id*.) This Court, like the court in *Stenson*, cannot know whether Franks will continue to meet these requirements in the future, even if he declares today his intention to do so. Any declaratory judgment regarding Franks' future benefits would be speculative and purely hypothetical.

Aetna has not threatened to deny Franks benefits in the future. The requirement Franks continue to provide proof of on-going entitlement to benefits cannot be construed as a "threat," but merely part of normal and proper claim administration under the Plan that Franks is relying on for his disability benefits.

For these reasons, Franks is not entitled to declaratory relief, or any other equitable relief.

E. Franks is not entitled to any remedy and cannot prove the necessary elements of his cause of action

Franks has received the available relief he seeks. Franks cannot obtain either compensatory or equitable relief, and he should not receive attorney's fees or prejudgment interest.

1. Franks is not entitled to attorney's fees because he did not obtain "some relief on the merits"

Defendants anticipate, and dispel here, any argument by Franks for recovery of fees. While an award of attorney's fees is discretionary, cases interpreting the ERISA fee provision have required at least some court involvement. ERISA states that:

> In any action under this subchapter . . . by a participant, beneficiary, or fiduciary, the court in its discretion may allow a reasonable attorney's fee and costs of action to either party.

29 U.S.C. § 1132(g)(1) (ERISA § 502(g)(1)).

The United States Supreme Court has held that before a court can consider awarding fees under ERISA, a party must show he or she has achieved "some relief on the merits." *Hardt v. Reliance Std. Life Ins. Co.*, 130 S. Ct. 2149, 2152 (2010); *Simonia v. Glendale Nissan/Infiniti Disability Plan*, 608 F.3d 1118, 1120-21 (9th Cir. 2010) (plaintiff must achieve some success on the merits before *Hummell* factors are even considered). The *Hardt* Court clarified "that, absent some degree of success on the merits by the claimant, it is not 'appropriate' for a federal court to award attorney's fees under [a similar statute]." *Id*. at 2158 (citing *Ruckelshaus v. Sierra Club*, 463 U.S. 680, 694 (1983)).

Here, Franks filed a premature lawsuit while Aetna's claim decision was pending and about to issue. Within the ERISA-mandated appeal timeframe and consistent with the Plan, Aetna decided to award Franks benefits. Aetna then timely determined Franks was disabled under the "any occupation" Plan definition. The results of these administrative claims handling procedures were communicated to Franks, his attorney, and the Court as soon as they were made.

Franks has achieved no relief at all from this Court related to this case or in terms of his lawsuit. The Court has not been asked to, nor is there any need to, adjudicate any issues with respect to Franks' claim for recovery of benefits.

It seems obvious that a plaintiff in an ERISA case who has not obtained any relief from a court cannot obtain an award of attorneys' fees. Perhaps this is why Defendants could find no post-*Hardt* cases awarding a plaintiff attorneys' fees in an ERISA case when she or he had not obtained any relief through the litigation.

The issue in *Hardt* was whether to apply the "prevailing party" analysis as presented in *Buckhannon Board and Care Home Inc. v. West Virginia Department of Health*, 532 U.S. 598 (2001)), to an award of ERISA attorneys' fees, or whether the "partially prevailing party" standard applies, as described in *Ruckelshaus v. Sierra Club*, 463 U.S. 680 (1983). Put another way, the question really was one of degree – that is, the threshold level of success a party needed before the court could contemplate exercising its discretion to award fees. In cases interpreting the "prevailing party" standard, courts held that a party needed to obtain a judgment (or other enforceable final decision) that resulted in "substantial success" on a "central issue" in the

litigation. *See Ruckelshaus, supra*, 463 U.S. at 688. By contrast, the *Ruckelshaus* "partially prevailing party" standard required "some degree of success on the merits." *Id*. at 694.

Thus, by adopting the *Ruckelshaus* analysis, *Hardt* only lowers the level of success required to seek attorneys' fees in an ERISA case, but does not abolish it. In fact, the court was clear that it never awarded a party attorney's fees when an alteration of the party's circumstances did not derive from some judicial action. *Buckhannon, supra*, 532 U.S. at 606 ("[n]ever have we awarded attorney's fees for a nonjudicial alteration of actual circumstances")(internal citations omitted). *Hardt* did not change this rule. Thus, because nothing Aetna did was caused by a judicial ruling, Franks' anticipated argument that his counsel's actions caused Aetna's appeal determination has no merit.

2. Franks is not entitled to interest on past benefits because there was no judgment and no finding Aetna acted wrongfully

"Whether interest will be awarded is a question of fairness, lying within the court's sound discretion, to be answered by balancing the equities." *Shaw v. International Assoc. of Machinists & Aerospace Workers Pension Plan*, 750 F.2d 1458, 1465 (9th Cir. 1985). However, a court's discretion is not unlimited. *See Hardt, supra*, 130 S. Ct. at 2158. *Hardt*'s requirement that a plaintiff achieve some success on the merits is the threshold that Franks must meet to allow a court even to consider whether to exercise its discretion. Because Franks failed to do so, an interest award is unwarranted.

a. Because there is no judgment, there can be no prejudgment interest award

Almost without exception, in all cases awarding interest on back benefits, there was either a judgment in plaintiff's favor, or some finding that the delay in benefits payments was wrongful. *See e.g. Dishman v. UNUM Life Ins. Co. of Am.*, 269 F.3d 974, 988 (9th Cir. 2001) (plaintiff awarded judgment granting benefits). Here, there has been no judgment, no opinions on the merits at all, and certainly no determination that Aetna (or the Sprint Defendants) acted improperly. Thus, this Court should not exercise its discretion to award prejudgment interest when there has been no relief on the merits and no finding of wrongful delay.

In *Smyrni v. U.S. Investigative Services LLP Plan*, 2010 U.S. Dist. LEXIS 20002 (N.D. Cal. 2010), there was an unopposed request for judgment interest. In that case, the plaintiff's demand for interest was not supported by any law, and the defendants failed to oppose the request.[5] The opinion noted the defendants failed to cite law that would require the court to deny the request for prejudgment interest, and issued its decision to award interest without analysis. Here, the situation is different and this Court should not entertain a request for judgment interest, even if made by Franks.

b. The court should deny an award of interest

The facts of *Smyrni* are distinguishable and an interest award would not be equitable. *See Fleming v. Kemper Nat'l Servs*., 373 F. Supp. 2d 1000, 1012 (N.D. Cal. 2005). An award of interest is meant to "compensate" a party for a wrongful delay in payment, *see Dishman, supra*, 269 F.3d at 988, but in *Smyrni*, the delay was significant and unexcused. Three years had passed between the plaintiff's initial eligibility for benefits and ultimate payment of those benefits. That appeal process lasted for 2 years and 9 months, and continued for almost a year after litigation was initiated.

Here, the entire length of time between the initial denial of Franks' claim and the award of benefits was one year and 117 days (June 19, 2009, to October 14, 2010). (*See* Misiaszek Decl. at ¶¶ 6, 34.) Within that time period, though, Franks did not even submit his appeal until November 6, 2009 – almost four months later. (*Id*. at ¶ 10, Exh. 7.) Even then, Franks' disclosures that additional potentially relevant information remained outstanding prevented Aetna from beginning its appeal review. (*Id*. at ¶ 34.) Less than a month later, requests by Franks' own counsel for extensions in which to submit additional medical evidence and an appeal analysis delayed the process by approximately nine months.[6] (*Id*.)

Finally, in July 13, 2010, Franks' counsel provided Aetna with some additional documents and represented his belief "that Aetna now has everything it needs in order to review and pay [Franks'] disability insurance claim." (*Id*. at ¶ 23, Exh. 19.) Even assuming that Aetna

[5] Defendants only opposed plaintiff's demand for an interest rate higher than the required Treasury Bill rate.
[6] December 4, 2009, through April 14, 2010, and April 19, 2010, through July 13, 2010.

could have begun its review immediately[7], the regulations promulgated under ERISA provide 45 days to consider the appeal, with additional extensions of 45 days on written notification. Aetna requested one 45-day extension. (*Id*. at ¶ 25, Exh. 21.) Therefore, Aetna's decision needed to be rendered by October 2, 2010. (*Id*. at ¶ 28, Exh. 24.) In fact, it was rendered on October 1, 2010 (*Id*. at ¶ 33), and was communicated orally to Franks' counsel that same day. (*See* Devlin Decl. at ¶ 5.) The letter commemorating the decision and the reasons on which it was based was sent by facsimile to Baum on October 14, 2010. (Misiaszek Decl. at ¶ 36, Exh. 27.) Franks' first benefits check was received October 25, 2010. (Devlin Decl. at ¶ 8, Exh. 5.)

Thus, of the one year and 117 days between the initial denial of benefits and the ultimate benefits award on appeal, Aetna only took 90 days to consider Franks' appeal. This length of time was reasonable, allowed by ERISA's regulations, and authorized by the Plan terms. For Franks to expect an award of interest based on his counsel's delays in providing information, authorizations, documents, and analysis would afford him a windfall rather than compensate him for a loss.

CONCLUSION

For the foregoing reasons, Defendants respectfully request this Court grant Defendants' motion for summary judgment.

DATED: October 20, 2011

Respectfully submitted,

GORDON & REES LLP

By: /s/ *Tad A. Devlin*
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[7] Aetna contends it was not able to because Franks' counsel subsequently represented that there still was more medical evidence, and counsel failed to timely provide an updated release.